GUEST REGISTRATION

PERSONAL INFORMATION

Name_____
Address_____
City/State/Zip_____
Home Phone_____
Mobile Phone_____
Employer_____
Work Phone_____ Ext._____
Social Security #_____DOB_____
Marital Status (Circle One) S M Gender (Circle One) M F
EMAIL ADDRESS_____

POLICY HOLDER INFORMATION

Name_____
Employer_____
Social Security #_____DOB_____
Dental Insurance_____ Group Number_____

WHOM MAY WE THANK FOR REFERRING YOU?

Family Member/Friend_____ Doctor_____
Internet/Google_____ Social Media_____
Mailer/Magazine_____ Drive-By_____
Other-Specify_____

EMERGENCY CONTACT

Name_____
Home Phone_____
Work Phone_____ Ext_____

AESTHETIC DENTISTRY
of Georgetown

MEDICAL HISTORY

Do you have any of the following?

Yes/No
___ ___Any heart problems
___ ___Abnormal blood pressure
___ ___Stroke
___ ___Circulatory problems
___ ___Excessive bleeding
___ ___Anemia
___ ___Arthritis
___ ___Respiratory problems
___ ___Epilepsy
___ ___Diabetes

Yes/No
___ ___Hepatitis A (infectious)
___ ___Hepatitis B (serum)
___ ___Jaundice
___ ___Malignancies
___ ___Rheumatic fever
___ ___Unfavorable reaction to dental anesthetic
___ ___Fainting tendency
___ ___Tuberculosis
___ ___Thyroid disease

Yes/No
___ ___Glaucoma
___ ___AIDS/HIV
___ ___Blood Transfusion
___ ___Sinus Problems
___ ___Botox Use
___ ___Do you use tobacco
How often_____
___ ___Are you a nursing mother
___ ___Are you pregnant
Due Date_____

Do you have a history of: rheumatic fever, heart murmur, artificial valve or joint replacement which now requires premedication?(circle which one) comments:_____
Are you allergic to any drugs? _____Please list_____
Are you currently taking any medications? _____Please list_____
_____
Have you taken medication for bone density or Osteoporosis? _____Please list_____
Are there any other medical conditions of which I should be aware? _____
Are you presently under the care of a physician? Y or N If so, for what?_____
Have you ever been hospitalized?_____What for?_____
_____
Do you have a family history of heart disease, diabetes, or periodontal disease? _____
Are you waking up frequently during the night? _____ Do you wake up with headaches? _____
Have you ever been treated for snoring or sleep apnea? _____ Have you had a sleep study? _____
Date of study _____ Have you ever used a CPAP? _____ If so, was it successful? _____

DENTAL HISTORY

Are you currently experiencing a toothache or any other pain in your head or neck? If so, please describe: _____
_____
Date of your last dental treatment or cleaning? _____ Date of last dental X-rays? _____What type?_____
Would you change anything about the appearance of your smile? _____
Do you have any of the following:

Yes/No
___ ___Periodontal disease
___ ___Abscesses
___ ___Sores (Ulcers)
___ ___Cold sores/Fever blisters

Yes/No
___ ___Halitosis (Bad breath)
___ ___Sensitivities (Hot, Cold Sweets, Biting)
___ ___Headaches

Yes/No
___ ___Bruxism (Grinding teeth)
___ ___Clicking/Popping TMJ
___ ___Pain/fatigue in jaw joint
___ ___Dizziness

Are there any other conditions or experiences of which I should be made aware of? _____

_____ _____
Guest Signature Date

AESTHETIC DENTISTRY
of Georgetown

FINANCIAL POLICY

We are pleased that you have chosen Dr. Holley for your dental needs. In order to better inform you, please read the following summary of our financial policy.

Insurance

You, as the patient, are responsible for all charges regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. We provide services as an out of network provider, and as a courtesy we are happy to file claims with your primary insurance company for services rendered. Your deductible, co-payment, and/or co-insurance are due at the time of service. However, if we have not received payment from your insurance company within 60 days from the date of the service, you will be expected to pay the balance in full.

Payment

We realize that patients have financial needs, and we will do our best to find a solution that will work best for you. We accept Visa, MasterCard, American Express, Discover, Care Credit, and personal checks with proper identification. Returned checks may be recovered electronically along with the state allowed recovery fee. Payment of co-insurance, deductible, and/or co-payment is required at the time the services are rendered unless other arrangements have been made in advance. There will be a $30 fee assessed for returned checks and accounts sent to collections. Patients with outstanding balances 60 days or more overdue must make arrangements for payment prior to scheduling future appointments.

Missed Appointments/Late Cancellations

Your appointment is time set aside especially for you. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time reserved for you. Please call our office and speak to an appropriate coordinator 24 hours prior to your appointment if you must cancel or reschedule. Unfortunately, if the required notice is not given, you will be charged a Late Cancellation/No Show Fee. Excessive abuse of this policy may result in discharge from the practice.

I have read and understand Dr. Holley's financial policy. I agree to assign insurance benefits to Dr. Holley when necessary. I also agree that should it become necessary to forward my account for collection proceedings, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collection.

_____ _____

Signature Date